Harris County

Retiree Resource Guide

2013-2014

THESE BENEFITS ARE EFFECTIVE MARCH 1, 2013 THROUGH FEBRUARY 28, 2014. **If there is any variation between the information provided in this Guide, the Plan Document or the Group contracts, the Plan Document and Group contracts will prevail.** ***This guide briefly describes, in non-technical language, the benefits offered to you and your family. It is not intended to modify the group policies and/or contracts between the carriers and the County. You may obtain a detailed description of coverage provisions including the Summary of Benefits Coverage (SBC) - English and Spanish versions, a Glossary of Terms—English and Spanish versions and/or Summary Plan Document (SPD) from Human Resources & Risk Management (HRRM) Employee Benefits. They are also available on the HRRM website at www.harriscountytx.gov/hrrm or use one of the following links to directly access the document:***

English version

www.harriscountytx.gov/cmpdocuments/63/doc/baseplansbc.pdf
www.harriscountytx.gov/cmpdocuments/63/doc/plusplansbc.pdf
www.harriscountytx.gov/cmpdocuments/63/doc/uniformglossaryenglish.pdf
www.harriscountytx.gov/cmpdocuments/63/doc/2012summaryplandocumentrev.pdf

Spanish version

www.harriscountytx.gov/cmpdocuments/63/doc/baseplansbcspanish.pdf
www.harriscountytx.gov/cmpdocuments/63/doc/plusplansbcspanish.pdf
www.harriscountytx.gov/cmpdocuments/63/doc/uniformglossaryspanish.pdf

All documents are available electronically and you may obtain a printed copy upon request, at no charge. Reference Page 1 for additional information about the SBC.

HUMAN RESOURCES & RISK MANAGEMENT
Retiree Benefits.....(713) 755-5117
Out of Area Toll Free.....(866) 474-7475
Visit us on the web: www.harriscountytx.gov/hrrm

MEDICAL COVERAGE
Aetna Member Services.....(800) 279-2401
Aetna Rx—Mail Order.....(866) 612-3862
On-site Representative.....(713) 755-5604

Resources for Living (EAP).....(866) 849-8229
Web: www.aetna.com and www.AetnaEAP.com

DENTAL COVERAGE
UnitedHealthcare DHMO & PPO.....(866) 528-6072
On-site Representative.....(713) 755-4157
Web: www.yourdentalplan.com/harriscounty

VISION COVERAGE
Block Vision.....(866) 265-0517
Web: www.blockvision.com

LIFE INSURANCE
Prudential Insurance Company.....(800) 524-0542

DEFERRED COMPENSATION/457 PLANS
VALIC Retirement.....(800) 448-2542
Web: www.valic.com

ING Financial Services.....(800) 525-4225
Web: www.ingretirementplans.com

Nationwide (PEBSCO).....(800) 677-3678
Web: www.nrsforu.com

RETIREMENT
Texas County & District Retirement System (TCDRS)..(800) 823-7782
Web: www.tcdrs.org

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(formerly Health Care Reform)

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Harris County determines benefits, eligibility and contributions for retirees and their dependents subject to amendment and discontinuance at any time.

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Resource Guide editor and designer, Krista Britt

On March 23, 2010, the Patient Protection & Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA) were signed into law and is now referred to as the "Affordable Care Act" or ACA.

On August 1, 2011, the Department of Health and Human Services (HHS) adopted additional guidelines for women's preventive services without cost sharing requirements effective the first plan renewal following the guideline implementation. As a result, these benefit enhancements are effective for Harris County enrollees on March 1, 2013:

Well-woman visits: An annual well-woman visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits if women and their providers determine they are necessary.

Gestational diabetes screening: For pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

Human papillomavirus testing (HPV): Beginning at age 30 (no more frequently than every 3 years).

STI counseling, and HIV screening and counseling: Annual counseling on sexually transmitted infections for all sexually active women.

Contraception and contraceptive counseling: All FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity as prescribed. This requirement does not include abortifacient drugs such as the "morning after" pill.

Oral contraceptives: If you obtain a prescription for a generic oral contraceptive you will not have a copay; however, **you will pay the applicable copay for a brand name drug if a generic version is available** and just as effective and safe for patient use.

Breastfeeding support, supplies, and counseling: In conjunction with a pregnancy, comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

Summary of Benefits Coverage (SBC) Under Section 2715 of the Public Health Service Act, created by Section 1001 of the Affordable Care Act, group health plans are required to provide clear, consistent and comparable information about your health plan benefits. The Summary of Benefits Coverage provided separately from the Resource Guide summarizes the key features of our medical plans including covered benefits, cost-sharing, coverage limitations and exceptions. Coverage examples illustrate how the plans might cover medical care in given situations. Though this document is informative, we always encourage you to review the Summary Plan Document located at www.harriscountytx.gov/hrrm or contact Aetna directly for an in-depth explanation of your medical benefits.

The Glossary of Health Coverage and Medical Terms created by the Department of Health & Human Services is a new resource to help you understand some of the most common language used in health insurance documents. **Both the Summary of Benefits Coverage (SBC) for the Base and Plus Plans and the Glossary of Health Coverage and Medical Terms are available in English and Spanish versions on the Harris County website at www.harriscountytx.gov/hrrm, or you may obtain a printed copy upon request. To obtain a printed copy of the SBC at no charge, contact the Benefits Division at (713) 755-5117 or toll free (866) 474-7475 and we will send it to you within seven days.**

2013-2014 PLAN CHANGES: The addition of women's preventive services as identified above.

ANNUAL ENROLLMENT FACTS FOR MEDICAL, DENTAL & VISION

Annual enrollment for the 2013/2014 plan year will be conducted from December 1 through December 31, 2012. Changes become effective March 1, 2013. You should carefully consider the insurance plans available to you and your dependents. **You may be able to add dependents to your insurance plan following a qualified change in family status; however, you will be responsible for absorbing the entire cost for your existing and newly added dependents.**

Harris **C**ounty will continue to comply with the provisions set forth in the Affordable Care Act (ACA). (Most of these provisions enhance retiree benefits.)

We are committed to providing you with a comprehensive benefits program. Our program allows you to customize your benefits package to best suit your needs and the needs of your family. Annual enrollment is your opportunity to make allowable changes in your benefits. This Resource Guide is designed to help you through the enrollment process.

Medical and dental plans each offer two options. Reference pages 12 - 20 for plan details. Everyone in the family must choose the same plan.

Choices made during annual enrollment will remain in place until the following enrollment period.

Retirees who do not return their completed annual enrollment paperwork indicating desired changes will be defaulted to the benefit selections chosen for the 2012-2013 plan year.

QUALIFIED STATUS CHANGE

Retirees may experience life changes during the calendar year and a change form is required. "Qualifying Events" include:

- Birth of your child
- Adoption or placement of a foster child
- Marriage, divorce or death
- Spouse loses coverage through employment
- Significant change in the financial terms of health benefits provided through a spouse's employer or another carrier
- Loss of eligibility for Medicare or Medicaid
- Loss of State Children's Health Insurance Program (SCHIP)

NOTE: Retirees may drop dependents at any time.

Changes must be requested within the same calendar year in which they occurred. **FAILURE TO DROP DEPENDENTS when required under this health plan may be considered INSURANCE FRAUD and may result in a referral to the District Attorney's office for investigation. Further, a retiree committing insurance fraud may be liable to reimburse the County for claims activity.**

Are you a retired Public Safety Officer? If so, you can have your insurance premiums deducted from your TCDRS pension check on a pre-tax basis.

Tired of receiving a bill each month, writing a check and mailing your insurance premium to the County?

Don't risk losing your coverage due to a late payment when you can enroll in direct debit today and your premiums will always be paid on time.

ELIGIBILITY & CHOOSING THE RIGHT PLAN

Submitting required documentation is key to adding dependents to your coverage.

Spouse:

A filed copy of a Formal Marriage License or Certificate of Informal Marriage.

Children:

A birth certificate or court documents showing legal guardianship or legal custody. Coverage is available up to age 26.

Stepchildren: A birth certificate or other court document listing the retiree's spouse as parent of the child, and the marriage license of the retiree and parent of the child. Coverage is available up to age 26.

Grandchildren:

- ⇒ Certification of Financial Dependency form (obtain from HRRM),
- ⇒ birth certificate of the grandchild, and
- ⇒ birth certificate of the grandchild's mother or father.
- ⇒ Coverage is available up to age 26.
- ⇒ The grandchild must be related to the retiree by birth or adoption and cannot be your spouse's grandchild.

NOTE: Grandchild must be claimed as a dependent on the retiree's Federal Tax return every year to remain on the plan. The Grandchild Audit occurs in June of each year.

Adopted Children: Certified copy of court order.

Foster Children: Foster care placement agreement between the retiree and the Texas Department of Family & Protective Services or its subcontractor.

CHOOSING THE BEST PLAN FOR YOU AND YOUR DEPENDENTS should be based on several things such as your personal medical condition and usage of services, financial situation, and your level of comfort with coinsurance vs. copayments. **Copayments do not apply to coinsurance, out-of-pocket maximums or annual deductible.** The following definitions may assist you in the decision-making process.

Copayment: the predetermined dollar amount you will pay for a service (Examples: physician office visits, walk-in clinics, urgent care, emergency room, physical therapy, counseling).

Coinsurance: percentage retiree is responsible for paying up to a specific dollar amount per calendar year. Covered services are paid from 50%-100% depending on the plan selected, service rendered and place of service.

Deductible: initial out-of-pocket costs that must be paid before the plan begins to pay benefits (Base Plan In-Network $500; Plus Plan In-Network $0).

The **Base** plan has set copayments for some in-network services, but requires coinsurance for ambulance, durable medical equipment, hearing aids, complex imaging, home health care, hospice, inpatient hospitalization, outpatient surgery, physician hospital services, private duty nursing and skilled nursing facility. The Base plan also has a $500 per individual in-network deductible with an individual maximum out-of-pocket coinsurance limit of $2,500 per calendar year. The deductible and coinsurance only apply where services are not indicated as set copayments.

The **Plus** plan has set copayments for most in-network services; however, this plan has a higher monthly premium contribution.

Your Aetna Choice POS II Plans do not require you to select a network primary care physician (PCP), although selecting a PCP is encouraged. These plans also allow you to self-refer to a specialist. Your choice of provider dictates the amount you will pay in copayments, coinsurance and/or deductibles.

AEXCEL SPECIALISTS AND OUT-OF-NETWORK COVERAGE

What is Aexcel®?

Aexcel is a designation for specialists in Aetna's performance network that have met certain standards for clinical performance and efficiency. These standards include managing Aetna patient volume, adhering to clinical guidelines, external recognition and board certification information specific to the physician's Aexcel specialty and demonstrating overall effectiveness in the delivery of care. Aexcel specialists are available in the following categories of care:

Cardiology	Obstetrics/Gynecology
Cardiothoracic Surgery	Orthopedic Surgery
Gastroenterology	Otolaryngology (ENT)
Neurology	Plastic Surgery
Neurosurgery	Urology
General Surgery	Vascular Surgery

For example, if you obtain specialty services from a dermatologist or other non-Aexcel specialty you will have a **$40 copay on the Base Plan and a $30 copay on the Plus Plan**. However, if you seek specialty services through an Aexcel specialty category such as cardiology and do not see an Aexcel designated cardiologist, **your copay on the Base Plan is $50 and on the Plus Plan is $40**.

Using Aexcel-designated providers will save you $10 per visit on copays. To find an Aexcel specialist login to www.aetna.com and select "Find a doctor, pharmacy or facility". Aexcel specialists are indicated with a blue star.

OUT-OF-NETWORK COVERAGE

Harris County has limits on authorized costs associated with Out-of-Network facilities/providers. Advise your participating physician that it is important to you that the highest level of benefit coverage is desired by ensuring that they refer you to only in-network facilities and providers with Aetna. This will result in savings for both you and the county.

To help curb excessive out-of-network facility/provider costs, the county has established a Limited Out-of-Network fee schedule that limits the Plan's exposure to the unreasonable cost for non-emergency services and procedures. If you use an out-of-network facility or provider, you will be responsible for paying the difference between the covered amount (which is based on established rates for our geographic area) and the amount the facility charges. If you incur non-covered expenses, they will not apply to your coinsurance maximum.

It is YOUR responsibility to make sure your physician, facility or hospital is in-network or you will pay out-of-network costs. You can help keep costs down by using in-network providers.

NOTE THE FOLLOWING:

- **There are no out-of-network benefits for health care services provided by North Cypress Medical Center. The only exceptions are for true emergency care provided in the emergency department and emergency inpatient admissions.**
- **If you are currently on dialysis, coverage is provided in-network ONLY.**

HARRIS COUNTY WELLNESS PROGRAMS

all is well at Harris County

Join the Harris County wellness community and start the journey to a healthier, happier you.

Get active with walking and wellness challenges and community events.

Stay well with programs that help you manage diabetes, have a healthier pregnancy, quit smoking and more.

Know your health risks by getting a yearly no-cost health screening or free on-site mammogram and taking an online health assessment.

Be informed on healthy eating, fitness, pregnancy and other important topics. While you're at www.wellathctx.com, get your monthly health tip and check the Wellness Calendar.

Celebrate success! Celebrate with others. Read success stories to get inspired.

Be a part of the Harris County wellness community

Visit www.wellathctx.com

Enter the password: WELL4HCTX

ARE YOU INTERESTED IN LEARNING MORE ABOUT HEALTH AND WELLNESS? Aetna Informed Health Line nurses can discuss more than 5,000 health and wellness topics.

Call them at (800) 556-1555 anytime you have a health question.

ENGAGE YOURSELF! BEGIN A NEW LIFESTYLE—YOU'LL FEEL BETTER AND LOOK BETTER!

Aetna Fitness℠ discount program that allows you to save on gym memberships!

Get preferred rates at your choice of over 10,000 gyms in the GlobalFit network. You also get:

- ⇒ **FREE guest pass at most gyms**
- ⇒ **Flexible membership options**
- ⇒ **Easy billing through your bank account or credit card**

Choose from GlobalFit's national network of gyms. To find a participating gym in your area visit www.globalfit.com/fitness. You can view details about any gym, including rates and amenities, and register for membership online or call GlobalFit toll free at 800-298-7800. A GlobalFit representative can answer your questions, send you a free guest pass, and help you join the gym of your choice. Gyms in the metro Houston area include 24-Hour Fitness, Jazzercise, Curves, Anytime Fitness and many other independent local gyms.

Save on home exercise equipment!

Build your home gym with discounts on elliptical trainers and treadmills. Also available are resistance bands, mats, yoga accessories and more.

IT'S NEVER TOO LATE TO START AN EXERCISE PROGRAM!

TIP...*DO YOU KNOW THAT A ROUTINE COLONOSCOPY is covered at 100% when using an in-network provider?* If additional diagnostic procedures are needed you will be responsible for the applicable copayment, coinsurance and/or deductible.

Simple Steps To A Healthier Life® Program

Step 1
Assess your health by completing the health assessment at www.aetna.com.

Step 2
Take action using a personalized Healthy Living Program.

Step 3
Learn to make informed health decisions.

When you feel good, it's easier to enjoy the people and things you love most. Simple Steps To A Healthier Life is an interactive online health and wellness program that can help you improve or maintain your health in ways that fit your lifestyle.

You start by taking an online Health Assessment that will help identify some of your health needs. Questions focus on health habits and all answers are kept secure and confidential. You will need your current lab and biometric results to input into the assessment including blood pressure, cardiac CRP, BMI, total cholesterol, LDL and HDL cholesterol, triglycerides, and fasting glucose. Even if you don't have all of these results, you can still complete your health assessment and fill these results in at a later date.

Online programs to help YOU reach YOUR goals	
Manage your weight: Reach your goal weight, and boost how active you are with Balance™.	Sleep better: Beat sleepless nights with strategies from Overcoming™ Insomnia.
Deal with stress: Find out where your tension comes from, and get proven strategies to stay calm under pressure with Relax™.	Quit Smoking: Get a quit plan that uses your strengths to help you get past old roadblocks with Breathe™.
Eat healthier: Get counseling one on one to learn better eating habits for life with Nourish™.	Be happier: Whether you have the blues or it's more serious, you can get confidential help that gets results with Overcoming™ Depression.

You'll get free online wellness coaching programs through HealthMedia® and learn strategies to fit healthy living into your busy life, at your own pace.

Aetna Compassionate Care℠

This is a comprehensive program to provide expanded benefits, nurse support and information to retirees and their families who are facing end-of-life and palliative care issues. Case management and bereavement services are covered up to twelve (12) months.

Palliative care aims to relieve physical symptoms of disease and provides emotional and spiritual support to patients and family members while respite care provides short-term services to seriously ill individuals and relieves primary care givers of some of the burden.

For more information visit:
www.aetnacompassionatecareprogram.com

Informed Health® Line

gives you easy access to credible health information. All Informed Health Line services are available 24 hours a day, 365 days a year on demand from your touch-tone phone. If you prefer to view health information online, simply login to **www.aetna.com, select "Health Programs",** then click on the link for the *Healthwise® Knowledgebase.*

24-Hour Nurse Line	Speak with a registered nurse who has experience in a variety of health topics at any time of the day.*
Audio Health Library	Phone in to choose from thousands of common health topics to listen to. Easily transfer to the Nurse Line for questions.
Healthwise® Knowledgebase	Search for detailed information about health conditions, medical tests and procedures, medications and treatment options.

Informed Health Line Nurses cannot diagnose, prescribe or give any medical advice. Contact your physician with any questions or concerns regarding your health care needs.

To reach the 24-Hour Nurse Line or Audio Health Library call 1-800-556-1555.

Aetna InteliHealth® is an exclusive resource that can be accessed online to find up-to-date health information and resources including:

To access, login to **www.aetna.com** and begin learning everything you ever wanted to know about health and medical conditions

- Information on diseases & conditions
- Articles on lifestyle improvement
- Gender and age specific health issues
- Medication information
- Health assessments
- Quizzes
- Medical dictionary
- Health calculators (BMI, etc.)
- Current health research news
- "How-to" slide shows
- Email health updates

Aetna Health Connections℠ Condition Management Program

This program is designed to help you or your eligible family member(s) learn more about your condition and work closely with your doctor to improve your health and quality of life. Educational information is provided and for high risk members, access to a registered nurse "Health Coach" is offered.

The adjacent list includes a few of the 35 conditions managed by this program. To learn more about Disease Management, login to **www.aetna.com**, select "Health Programs", then "Disease Management program". **No computer…no problem! Just call (866) 269-4500 to get started in disease management.**

If you receive a call or letter from Aetna, please return their call or contact them as requested. **All information is confidential with Aetna and is not shared with Harris County.**

- Asthma
- Back pain
- Cancer
- Cerebrovascular Disease
- Chronic Heart Failure
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Cystic Fibrosis
- Depression
- Diabetes
- Digestive
- HIV
- Hepatitis
- Hypertension
- Inflammatory Bowel Disease
- Kidney Failure
- Peripheral Artery Disease
- Rheumatoid Arthritis
- Sickle Cell Anemia
- Weight Management

Aetna Resources For Living *(formerly Employee Assistance Plan aka EAP)*

Confidential assistance is available 24 hours a day, 7 days a week when using the Aetna ***Resources For Living*** (formerly Employee Assistance Plan, aka, EAP) program.

This is a service provided as part of your benefits to you or any member of your household at no additional cost. You can turn to ***Resources for Living*** *(EAP)* for help with anything that interferes with your job or personal life such as:

Stress management	Family or parenting issues
Substance abuse/misuse	Work/life balance
Burnout	Marital/relationship problems
Child and elder care	Anxiety
Depression	Anger management
Legal concerns	Financial issues
Coping with change	Self-esteem

Aetna Resources For Living understands that some days can be tough to manage the competing priorities in our lives and keep it running smoothly. Sometimes life can become work and work can become your life. Either way, they are there to help you balance the two. Maybe you just need someone to talk to about a recent transition or conflict at work, or maybe you're looking for some guidance with your personal relationships...

Benefits of the Resources For Living:

- ⇒ **5 FREE counseling sessions *per issue*, per year**
- ⇒ **Refresh Your Mind and Reenergize your life!**
- ⇒ **Free initial legal consultation, discounts on continuing legal consultation services**
- ⇒ **Free initial financial consultation**
- ⇒ **MOST IMPORTANTLY, ALL INFORMATION IS CONFIDENTIAL BETWEEN AETNA RESOURCES FOR LIVING AND YOU!**

WHAT ARE YOU WAITING FOR?

Visit www.AetnaEAP.com and enter

Company ID: EAP4HCTX

or call 1-866-849-8229

ASSISTANCE IS JUST A PHONE CALL OR CLICK AWAY

FOR FREE SERVICES!

Most people think of an EAP as a place to call when they have a crisis or an urgent need for emotional or mental health support. ***Resources For Living*** removes the stigma that often comes with the term EAP and continues to provide that same level of support while adding assistance with all of the following:

- ⇒ Work/life balance
- ⇒ Improved lifestyle
- ⇒ Better physical and mental health
- ⇒ Total well-being

WELLNESS & TECHNOLOGY

The Next Generation of Consumerism—iTriage—Connecting consumers to information and care on-the-go.

With iTriage, healthcare is on the go with a consumer. The iTriage app provides a Symptom-to-Provider pathway , connecting patients who are actively looking for healthcare with providers who have the capability and capacity to deliver that care.

You can identify possible causes, research diseases, procedures, tests and medications, and decision support to find the most appropriate provider to treat your symptoms.

iTriage can even help a consumer book an appointment with a physician or pre-register with an Emergency Department.

This is healthcare's leading mobile platform to empower people to make better healthcare decisions, and improve healthcare delivery.

GO TO YOUR APP STORE TODAY TO DOWNLOAD THIS FREE APP!

Download iTriage FREE for your smartphone today. Available on iPhone, Android & more.

iPhone, iPod Touch, iPad

iTriage is a free application for your iOS device. Download the iTriage app directly from your Apple device or go to the iTunes App Store.

Download iTriage Now »

Android Phone, Android Tablet

iTriage is a free application for Android phones and tablets on the market today. Download the iTriage app from the Android Marketplace.

Download iTriage Now »

www.iTriage.com

aetna℠ *WE HAVE AN "APP" FOR THAT!*

The Aetna Mobile app is available for Android™smartphones, iPhone®, iPod touch®, iPad™, and BlackBerry® Curve™ models . The Aetna application or "app" enhances the capabilities of Aetna Mobile Web by leveraging key Android smartphone functions. Similar to the Aetna app for iPhone and Blackberry users, the Aetna apps are free and allow members to:

- ☑ **Search for a doctor or facility based on their current location and get turn-by-turn directions with the built-in Global Positioning System (GPS)**
- ☑ **View their Aetna ID card information**
- ☑ **Check the status of recent claims**
- ☑ **Access their Personal Health Record to view items like "Alerts & Reminders, Emergency Information, Medications and Tests & Procedures" while on the go**
- ☑ **Get a drug cost estimate before a prescription is filled**
- ☑ **View their coverage and benefits, including account balances**

To download the app...

- ⇒ **Android™ users go to the Marketplace and search for "Aetna" to download the app.**
- ⇒ **iPhone®, iPod touch® and iPad™ users can simply tap the App Store logo, then type "Aetna Mobile" in the search box.**
- ⇒ **BlackBerry® Curve™ users go the BlackBerry App World™ storefront and download the Aetna mobile "app".**

ARE YOU INTERESTED IN VIEWING AND MAINTAINING YOUR PERSONAL HEALTH RECORD ONLINE?

You can make history by putting the Aetna® Personal Health Record to work for you. This secure, private, online resource makes it easy for you to view, access and manage your health information—and share it with your doctors. Go to www.aetna.com and select "View Personal Health Record".

DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME) IS A COVERED BENEFIT

BASED ON THE FOLLOWING CONDITIONS:

No more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- **made to withstand prolonged use;**
- **made for and mainly used in the treatment of a disease or injury;**
- **suited for use in the home;**
- **not normally of use to a person who does not have a disease or injury;**
- **not for exercise or training.**

The accessories needed to operate your **Durable Medical Equipment (DME)** are covered under your DME benefit at 90% after deductible for Base Plan members and at 100% for Plus Plan members when using in-network providers. You can order your diabetic supplies at no cost via the following Aetna DME providers: Sterling Medical Services (800) 216-5500 and Medical Plus Supplies (713) 440-6700.

Aetna Informed Health Line nurses can discuss more than 5,000 health and wellness topics. Call them at (800) 556-1555 any time you have a health question.

The ugly truth…

By the year 2020, half of all American adults will be diabetic or pre-diabetic and 75% will be obese or overweight. By the year 2030, it is projected 366 million people will suffer from diabetes.

Are You Diabetic? If so, it's important for you to have the best possible care and monitoring available to control your condition. DiabetesAmerica is your "one-stop-shop" for diabetes care. It provides comprehensive diabetes care, management and education services at a single location**.**

Diabetes America™

Free services include:

- Physician care
- Certified and personalized diabetes education
- Certified diabetes nutritional counseling
- Exercise and lifestyle counseling and support
- Case management and monitoring
- Telephonic support/website access
- Eye, foot and cardiovascular screenings
- On-site labs
- Annual retinal exam
- Free glucose monitor

NO OFFICE VISIT COPAY AND EIGHT (8) LOCATIONS IN THE HOUSTON AREA FOR YOUR CONVENIENCE.

For locations, information and appointments, call 1-888-693-4223 or visit www.diabetesamerica.com.

RECOMMENDED PREVENTIVE HEALTH/SCREENING/VACCINE

Hepatitis B (HepB)	3-4 doses—1 dose at birth; 1 dose 1-2 months later; 1 dose at 4 months of age; and 1 dose between 16-18 months
Hepatitis A (HepA)	2 doses—1 dose between 12 and 23 months of age and 1 dose at least 6 months later
Rotavirus	2-3 doses—1 dose each at 2, 4 and 6 months of age
Diphtheria-Tetanus-Pertussis (DTaP)	5 doses—1 dose each at 2, 4 and 6 months of age; 1 dose between 15 and 18 months of age; and 1 dose between 4 and 6 years of age
Inactivated Polio (IPV)	4 doses—1 dose each at 2 and 4 months of age; 1 dose between 6 and 18 months of age; and 1 dose between 4 and 6 years of age
H. Influenza Type B (Hib) (may be combined with DTaP) & Pneumococcal Conjugate (PCV)	4 doses—1 dose each at 2, 4 and 6 months of age; and 1 dose between 12 and 15 months of age
Measles-Mumps-Rubella (MMR) & Chicken Pox (Varicella)	2 doses—1 dose between 12 and 15 months of age; and 1 dose between 4 and 6 years of age
Influenza	Every flu season—beginning at 6 months of age
Meningococcal	1 dose between 11 and 12 years of age
Tetanus-Diphtheria-Pertussis (Tdap)	1 dose between 11 and 12 if the childhood DTP/DTap series is complete and has not received Td booster
Human Papillomavirus (HPV)	3 doses (females) between 11 and 12 yrs; second dose 2 months later, third dose 6 months after 1st dose
Blood Pressure	Every 2 years—18 years of age and older
Body Mass Index (BMI)	Periodically—18 years of age and older

Cholesterol	Government guidelines state that healthy adults who are age 20 years or older should have a cholesterol test done once every 5 years.
Glucose (diabetes blood sugar test)	Beginning at age 45, then every 3 years unless you have other risk factors, then testing should occur every year
Mammogram	Every 1-2 years—women 40 years of age and older
Cervical Cancer	Every 1-2 years—Beginning at 21 years of age or earlier if sexually active; if 30 years of age and older, either a Pap Smear every 2-3 years after 3 consecutive normal results or HPV DNA test plus a Pap smear every 3 years if results of both tests are negative. Women 70 years of age and older may stop screening.
Chlamydia	Routinely—women 24 years of age and younger if sexually active
Osteoporosis (Bone Density Test)	Routinely—women 65 years of age and older
Prostate Cancer	Between 50-75 years of age—yearly screening with high-sensitivity fecal occult blood testing, or sigmoidoscopy every 5 years with high-sensitivity fecal occult blood testing every 3 years
Colonoscopy	Men and women beginning at age 50, once every 10 years
Depression/Alcohol Misuse/Tobacco Use	Routinely—18 years of age and older
Tetanus-Diphtheria-Pertussis (Td/Tdap)	1 dose Td booster every 10 years
Pneumococcal	1 dose—65 years of age and older
Zoster (shingles)	1 dose—60 years of age and older

NOTE: Preventive health, screening and vaccines are a covered benefit on our plans based on frequency and age specific guidelines indicated.

MEDICAL BENEFITS COMPARISON—BASE PLAN VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN PREFERRED BENEFITS (In-Network)	BASE PLAN NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Plan Deductible (per calendar year)	$500 Individual, $1,500 Family	$1,000 Individual $3,000 Family	None	$1,000 Individual $3,000 Family
Deductible Carryover	None	None	None	None
Coinsurance Limit / Payment Percentage (excludes deductible; once family coinsurance is met, all family members will be considered having met the deductible)	$2,500 Individual $7,500 Family	$8,000 Individual $24,000 Family	None	$8,000 Individual $24,000 Family
Lifetime Maximum	Unlimited except where otherwise indicated	$1,000,000	Unlimited except where otherwise indicated	$1,000,000
Acupuncture	Up to $500 per calendar year (no deductible or coinsurance applies)	Up to $500 per calendar year (no deductible or coinsurance applies)	Up to $500 per calendar year (no deductible or coinsurance applies)	Up to $500 per calendar year (no deductible or coinsurance applies)
Alcohol & Drug Abuse Services—Inpatient	80% after deductible	50% after deductible	$500 per confinement copay	60% after deductible
Alcohol & Drug Abuse Services—Outpatient	100% after $40 copay	50% after deductible	100% after $40 copay	60% after deductible
Allergy Testing—includes serum, injections and injectable drugs (Allergy Specialist only)	100% after $40 office visit copay (waived for injection if no office visit charge)	50% after deductible	100% after $40 office visit copay (waived for injection if no office visit charge)	60% after deductible
Ambulance	90% after deductible	90% after deductible	100% coverage	100% coverage
Basic Infertility Services—Diagnosis & Treatment	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded	Payable as any other covered expense; 50% coverage for insemination; fertility drugs excluded
Chiropractic	$40 copay, up to $600 per calendar year (no deductible or coinsurance applies)	50% after deductible; up to $600 per calendar year	$30 copay, up to $600 per calendar year (no deductible or coinsurance applies)	60% after deductible; up to $600 per calendar year
Complex Imaging—MRI, PET, CT scan, etc. (pre-certification required)	90% after deductible	50% after deductible	100% coverage	60% after deductible
Diagnostic X-ray and Laboratory	100% coverage	50% after deductible	100% coverage	60% after deductible
Durable Medical Equipment	90% after deductible	50% after deductible	100% coverage	60% after deductible

NOTE: Limits for the Base and Base Plus Plans are combined for both preferred and non-preferred benefits. Please reference your Plan Document for a complete listing of covered services, reimbursement amounts, limitations and exclusions.

MEDICAL BENEFITS COMPARISON—BASE PLAN VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN PREFERRED BENEFITS (In-Network)	BASE PLAN NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Emergency Room	**$300 copay**, waived if admitted	**$300 copay**, waived if admitted	**$300 copay**, waived if admitted	**$300 copay**, waived if admitted
Hearing Aids—one pair every 36 months with a maximum benefit of $1,500	80% coverage, no deductible	80% after deductible	80% coverage, no deductible	80% after deductible
Home Health Care (100 visits per calendar year)	90% after deductible	50% after deductible	100% coverage	60% after deductible
Hospice Care—Inpatient & Outpatient	90% after deductible	50% after deductible	90% after $250 deductible	60% after deductible
Hospital Services—Inpatient	80% after deductible	50% after deductible	$500 per confinement copay*	60% after deductible
Hospital Services—Outpatient	80% after deductible	50% after deductible	100% after $300 copay for surgical procedures, 100% coverage for non-surgical	60% after deductible
Maternity (coverage includes voluntary sterilization)	Payable as any other covered expense	Payable as any other covered expense	Payable as any other covered expense	Payable as any other covered expense
Mental Health—Inpatient coverage	80% after deductible	50% after deductible	100% after $500 per confinement copay	60% after deductible
Mental Health—Outpatient coverage	100% after $30 copay	50% after deductible	100% after $30 copay	60% after deductible
Outpatient surgery (facility) - (Except in physician's office when office visit copay applies)	80% after deductible	50% after deductible	100% after $300 copay	60% after deductible
Physician Hospital Services	80% after deductible	50% after deductible	100% coverage	60% after deductible
Preventive Care** (Routine physicals, immunizations and tests)	100% coverage	50% after deductible	100% coverage	60% after deductible

***For inpatient maternity, copayment applies to mother and each child delivered.**

****PREVENTIVE CARE—In accordance with the Affordable Care Act (ACA), preventive care services include age appropriate or risk status screenings, standard immunizations recommended by the American Committee on Immunization Practices and all United States Preventive Services Task Force A and B recommendations. Examples of these services include well-child immunizations and exams, well-man and woman exams, and screenings as adopted by HHS guidelines.**

NOTE: Limits for the Base and Base Plus Plans are combined for both preferred and non-preferred benefits. Please reference your Plan Document for a complete listing of covered services, reimbursement amounts, limitations and exclusions.

MEDICAL BENEFITS COMPARISON—BASE PLAN VS. PLUS PLAN

PLAN FEATURES/SERVICES	BASE PLAN PREFERRED BENEFITS (In-Network)	BASE PLAN NON-PREFERRED BENEFITS (Out-of-Network)	BASE PLUS PLAN PREFERRED BENEFITS (In-Network)	BASE PLUS PLAN NON-PREFERRED BENEFITS (Out-of-Network)
Primary Care Physician Visits (excludes Mental Health/Alcohol/Drug)	100% after $25 copay	50% after deductible	100% after $20 copay	60% after deductible
Specialist Office Visits Participating Aexcel providers Non-Aexcel participating providers	 100% after $40 copay 100% after $50 copay	50% after deductible	 100% after $30 copay 100% after $40 copay	60% after deductible
Private Duty Nursing—Outpatient (70 shifts per calendar year)	90% after deductible	50% after deductible	100% coverage	50% after deductible
Residential Treatment Facility	80% after deductible	50% after deductible	$500 copay	60% after deductible
Routine Gynecological Care Exam Coverage is limited to one routine OB/Gyn exam per calendar year including charges for one pap smear and related fees.	100% coverage	50% after deductible	100% coverage	60% after deductible
Routine Mammography—Ages 35-40 one base-line; age 40+, one every calendar year	100% coverage	50% after deductible	100% coverage	60% after deductible
Short-Term Rehabilitation—physical, speech & occupational therapy (60 visits per calendar year)	100% after $25 copay	50% after deductible	100% after $20 copay	60% after deductible
Skilled Nursing Facility (100 days per calendar year	90% after deductible	50% after deductible	100% coverage	60% after deductible
Urgent Care Provider	100% after $50 copay	50% after deductible	100% after $50 copay	60% after deductible
Walk-in Clinics	100% after $25 copay	50% after deductible	100% after $20 copay	60% after deductible
Women's Health—includes well woman exam, screening, testing , contraceptives, breast feeding supplies/support*	100% coverage	50% after deductible	100% coverage	60% after deductible

*reference the Summary Plan Document available at www.harriscountytx.gov/hrrm for details regarding coverage

HARRIS COUNTY PRESCRIPTION DRUG BENEFITS

	Percentage You Pay	Minimum Copay	Maximum Copay
RETAIL			
Generic	25%	$5	$35
Brand	30%	$25	$100
Specialty	30%	$50	$200
MAIL ORDER			
Generic	25%	$10	$70
Brand	30%	$50	$200

Price-A-Drug

BEFORE YOU GO TO THE PHARMACY OR MAIL YOUR PRESCRIPTION TO AETNA RX HOME DELIVERY, CHECK PRICE-A-DRUG AT www.aetna.com. Price-A-Drug provides cost information for prescriptions at both retail and mail order so you can determine the least expensive method prior to having the prescription filled.

You can also use this online feature to obtain information about less expensive bioequivalent or therapeutic alternatives or contact Aetna Customer Service at (713) 755-5604 or toll free (800) 279-2401.

PLANNING A TRIP? DON'T FORGET YOUR MEDS!

Mandatory Generic Plan

This is a mandatory generic prescription drug plan. Prescriptions written for a brand medication will be dispensed as a generic, if available (or becomes available while the Rx is active). If a brand medication is necessary, the doctor must write/sign DAW (dispense as written) or brand necessary on the prescription. If this is not on the script and a generic is available, the member will receive the generic medication.

If the member or physician requests brand name when a generic is available, the member pays the brand copay plus the difference between the generic price and the brand price.

Bulk Chemicals and Compound Drugs

- The County's prescription drug benefit excludes bulk chemicals.
- All compound drugs made with bulk chemicals included on Aetna's Bulk Chemical Exclusion List as amended and administered for Harris County will be excluded from coverage.
- Covered compound drugs will require a brand level member copay responsibility.

Specialty Medications

Specialty medications/self-injectable drugs are available only for a 30-day supply through the Aetna Specialty Pharmacy OR an Aetna designated and approved provider after the third fill at a retail pharmacy.

Maintenance Prescriptions

If you recently filled a maintenance prescription, and your physician changes/increases your dosage, or if you are just reordering the maintenance medication and you are sending in a new prescription, you must have used 2/3 of your prescription prior to mailing in your new prescription.

IMPORTANT PRESCRIPTION DRUG INFORMATION

Would you like to save money on your prescriptions?

The **Save-A-Copay Program** is a consumer focused, VOLUNTARY program that offers retirees and/or their dependents a prescription drug copayment savings opportunity. If you currently are utilizing one of the following brand name drugs and are willing to switch to a lower cost preferred generic drug, you will have no copayments for six months! If you qualify for this program Aetna will send a letter to you encouraging your participation.

- **Sleep Disorders (Hypnotics):** Ambien, Lunesta, Sonata, Rozerem
- **Seizure Disorders (Anti-epileptics):** Lamictal, Trileptal, Lamictal XR
- **Attention Deficit Disorders (Stimulants):** Concerta, Focalin XR, Strattera
- **Hypertension (ARBs-ACEs):** Atacand, Avapro, Benicar, Teveten
- **Non-Sedating Antihistamines (NSAs):** Clarinex, Clarinex D, Xyzal
- **Nasal Steroids:** Beconase AQ, Flonase, Nasacort AQ, Rhinocort
- **Overactive Bladder (OAB):** Detrol, Detrol LA, Ditropan XL, Sanctura, Sanctura XR, Toviaz
- **Benign Prostatic Hypertrophy (BPH):** Flomax

This program is available for prescriptions filled at participating retail and mail order pharmacies. When using mail order you will not pay any copayments on two 90-day fills.

Each person's treatment is unique. Talk to your doctor first to find out if a preferred generic drug may be right for you.

Step-Therapy precertification is required for **Proton Pumps Inhibitor (PPI) prescriptions.** With **step-therapy**, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first or unless the **prescriber** obtains a medical exception. The plan will not cover certain **step-therapy** drugs if your **prescriber** does not prescribe a prerequisite drug first or fails to obtain a medical exception unless the corresponding prerequisite therapy drug(s) are used first. Prerequisite therapies and any medical exception prescriptions will be subject to dose and quantity recommendations outlined by the manufacturer.

Examples of PPI prescriptions: Aciphex, Protonix, Prevacid, Nexium and Prilosec.

- **Multiple Prescriptions:** If you submit new prescriptions all on one script, and not all are available at one time, the order could be delayed by 24-48 hours. If the remaining prescription(s) are not available within the 7-10 day processing period, the order will then be split into 2 separate orders in an effort to avoid further delay.

- **Prescription Narcotics:** Some Level II drugs (narcotics) can be filled via mail order (ARxHD). They must be mailed in on the prescribing physician's letterhead and must include the *member's name, Aetna identification number, and the medical diagnosis. Some of these drugs may be subject to quantity limits.*

- **Faxing prescriptions:** Physicians can fax prescriptions for mail order processing. The prescription must be submitted on the physician's office letterhead and must include the member's name and Aetna identification number. Prior to processing faxed prescription(s), the member must have completed and submitted an ARxHD registration form. Members cannot fax prescriptions for filling via mail order.

- **Filing paper claims for your prescriptions?** Talk to your pharmacist about calling Aetna Pharmacy Management for assistance in submitting your claim electronically, especially if you have two insurance carriers.

- **TAKING A TRIP?** If you know you will run out of your prescription medication, and it is too soon to refill prior to your departure, call Aetna Pharmacy Management (APM) for a "Vacation Override" at (800) 238-6279. You will need to provide your departure date and return date to the representative. Medication can be picked up as early as 3 days prior to your vacation departure date. In most instances you will receive a maximum three month supply of medication.

UnitedHealthcare Dental®
A UnitedHealth Group Company

UNITEDHEALTHCARE DENTAL PLANS - DHMO & PPO PLAN OPTIONS

OPTIONS: Harris County offers your dental benefits through UnitedHealthcare Specialty Benefits and continues to provide two dental options:

⇒ **A Dental Health Maintenance Organization (DHMO) and a Dental Preferred Provider Organization (PPO) plan.**

⇒ **Either plan is available to retirees and included in the cost (if applicable) of the medical plan.**

⇒ **If you choose to enroll your dependents, you will be responsible for their portion of the monthly premium.**

QUESTIONS? CALL CUSTOMER SERVICE 24/7

UnitedHealthcare Dental assistance is available 24 hours a day, 7 days a week. You can check eligibility, claims, determine out-of-pocket costs using the Treatment Cost Calculator and print or request your plan information…either online or through advanced telephone technology. Call (866) 528-6072.

Register for online access at:

www.yourdentalplan.com/harriscounty (registration and login button located at the bottom center of the home page) or call the toll-free number on your member ID card and follow the prompts for IVR (Interactive Voice Recognition) assistance.

UnitedHealthcare Dental HMO*	UnitedHealthcare Dental PPO**
No calendar year maximums; no yearly deductibles	$1,750 calendar year maximum; $50 yearly individual deductible ($150 for family)
Basic care provided by network general dentists selected at enrollment. Members may change their designated dentist by contacting UnitedHealthcare Dental customer service by the 20th of the month. Requested changes will be effective the first of the following month.	You may receive care from any licensed dentist; network dentists have agreed to accept negotiated fees as payment in full with no "balance billing".
Each family member may select a different UnitedHealthcare Dental network general dentist (remember to include the Practice ID number when enrolling).	Non-network dentists could "balance bill", which may result in higher out-of-pocket costs (For more information, see the Benefit Summary or determine out-of-pocket costs by using the online Treatment Cost Calculator).
Covered procedures and copayments are listed on the Schedule of Benefits and may be found on: www.yourdentalplan.com/harriscounty	All claims are paid based on the percentages of the Maximum Allowable Charge.
When specialty care is required, your selected general dentist and UnitedHealthcare Dental Customer Service Representative will assist in managing your referral.	If you require specialty care, you may see any specialty care dentist you choose. When you receive care from a network dentist, you may save on your cost of care.
No waiting periods.	**New enrollees: 6 month waiting period on endodontic procedures and all major services (also applies to newly added dependents of current retirees).**
Adult & child orthodontics is included in the DHMO plan.	Orthodontia is not a covered benefit in the PPO plan.
No claim forms are required.	Claim forms may be required when a non-network dentist is used.

* Benefits for the UnitedHealthcare Dental DHMO plans are provided by the following: UnitedHealth Group company, National Pacific Dental, Inc.

** Benefits for the UnitedHealthcare Dental PPO plans are provided by UnitedHealthcare Insurance Company, located in Hartford, Connecticut.

COMPARE THE DHMO AND PPO DENTAL PLANS TO MAKE THE RIGHT DECISION FOR YOU AND YOUR FAMILY

WHICH PLAN IS BEST FOR ME?

The DHMO plan provides comprehensive dental care with defined copayments for each covered procedure. You select a participating DHMO dentist from a network of providers and follow the plan rules/guidelines for services provided.

The PPO plan offers members a choice of dentists in-network, and the option to go out-of-network for services at a higher cost share. The plan includes an annual deductible and a calendar year maximum. With this plan you pay a higher percentage of costs for services.

Choose the plan that best suits your needs for the upcoming benefit year.

UnitedHealthcare DHMO Plan

Remember to select a dentist from the *UnitedHealthcare* Dental Directory or Dentist Locator on www.yourdentalplan.com/harriscounty for yourself and each of your enrolled dependents. Indicate the Practice ID Number in the space on your enrollment form for each person enrolled.

You can obtain a complete Schedule of Benefits with covered procedures and copayments along with Exclusions & Limitations available online at www.harriscountytx.gov/hrrm or www.yourdentalplan.com/harriscounty. You may also request a copy by calling customer service at the number located on your member ID card.

An Evidence of Coverage document may also be requested or viewed online and provides additional information about how to get the most from your *UnitedHealthcare* Dental HMO plan. Please take time to review this information before making dental benefit decisions.

DHMO members: check out the dental health and wellness link at www.yourdentalplan.com/harriscounty.

UnitedHealthcare PPO Plan

There is no need to pre-select a dentist - you can receive treatment from any dentist – network or non-network. If you decide to use a network dentist, you can log on to **www.yourdentalplan.com/harriscounty** to browse the Dental Directory or Dentist Locator to help you find a dentist. When choosing a dentist, if you choose to receive care from a *UnitedHealthcare Dental* network dentist, you could save on your out-of-pocket costs. Network dentists have agreed to negotiated fees as payment in full with no balance billing.

Your PPO Costs

Payment of claims is based on a Maximum Allowable Charge (MAC). The Maximum Allowable Charge is set by *UnitedHealthcare Dental* and uses negotiated rates with network dentists. This MAC is the most that *United Healthcare Dental* pays for a plan's covered dental procedure.

A Summary of Benefits includes the information about percentage of coverage by procedure category along with Exclusions & Limitations. After reviewing the plan documents, if you have any questions, a customer service representative will be happy to help you. Or, you may download a copy of the Certificate of Coverage at **www.harriscountytx.gov/hrrm.**

Included with your PPO dental plan:

Prenatal Dental Care Program: Women in their second and third trimester are eligible for this program. When visiting your dentist you need to supply the name and contact number of your OB/GYN. You will then receive additional cleanings or periodontal maintenance, at little or no cost, if the need is determined by your dentist.

Oral Cancer Screening: Individuals who are determined at-risk by their dentist who are 30 years of age or older may be eligible for this once-yearly, light-contrast screening.

DENTAL WELLNESS AND ESTIMATING THE COST OF TREATMENT

WELLNESS SCREENING Included with your Dental HMO:

The *UnitedHealthcare Dental* HMO Wellness plan, through its six (6) Centers of Excellence, created a program that makes wellness a priority by performing a variety of unique services. By simply visiting the dentist, individuals might find that they may save more than their teeth and gums. It may just lead to early diagnosis, referral for and treatment of a variety of diseases.

- The Centers of Excellence offer free, possibly life-saving, wellness screening services. Members set an appointment and complete a questionnaire. The dentist makes an assessment and provides appropriate screening(s) for any or all of four conditions.

- Screenings may help determine if a member is 'at-risk' for oral cancer, diabetes, or cardiovascular disease, and may lead to a referral for these conditions.

- As part of the wellness visit, attending dentists provide counseling and materials about the impact of tobacco use, obesity and oral piercings as well as information about oral disease and other medical conditions.

What is the difference between Routine Cleaning and Deep Cleaning?

"Routine Cleaning" (prophylaxis) is the removal of normal tartar build-up and polishing teeth to remove stains. If you see your dentist regularly and have your teeth cleaned twice a year, a routine cleaning will likely be your dentist's prescription.

"Deep Cleaning" is a term used to describe scaling and root planing, a procedure that removes plaque and tartar build-up on teeth below the gums. Usually, when you need a deep cleaning, it is a sign that your oral health has changed, typically due to gingival (gum) inflammation. There could be several reasons for the change…periodontal disease, stress, pregnancy, tobacco use, or a change of medication – even a simple change in brushing or flossing habits.

How much your dental treatments will cost

UnitedHealthcare Dental is committed to helping make the most of your dental plan benefits, by getting actual prices for treatments based on your individual plan, comparing the rates charged by different providers and seeing your out-of-pocket cost so you can plan ahead. We have created an easy-to-use tool: the Treatment Cost Calculator.

With the Treatment Cost Calculator, you can always make an informed choice about your dental treatments. It's easy to use and available to members 24 hours a day at www.myuhcdental.com.

Here's how it works:

1. To get started, visit www.myuhcdental.com and select Plan Info > Treatment Cost Calculator.
2. At the next screen, log in with your username and password. If you haven't previously registered at www.myuhcdental.com, you can register now.
3. At the next screen, you'll enter information about the practitioner performing the procedure.
   You'll need the following information:
   - The approximate date of the procedure
   - The Practitioner ID. To find the ID of a network practitioner, click the link to search for dentists who perform the procedure
4. At the next screen, you'll enter information about your procedure. Select the procedure from the list of common treatments shown. You can also enter the procedure code, if you know it, or display a list of procedure codes.
5. Your treatment cost results will be displayed, including the cost of the service based on your specific plan; the amount you're responsible for (coinsurance); any limitations or waiting periods in your plan; and your annual deductible, which is the amount you must pay each year before your plan starts paying benefits.
6. From the treatment cost results page, you can display your dental benefits summary, which lists your plan features, including in- and out-of-network coverage rates, your annual deductible and your annual maximum.

IMPORTANT DENTAL INFORMATION

It's been said that people typically visit their dentist more often than they visit other doctors. It's important to know that as health care becomes more integrated and dentists increasingly focus on more than just teeth, they are becoming indispensable members of the larger health care team.

The bacteria that inhabit the mouth, causing tooth decay and gum disease, may be found elsewhere in the body. Though there may be no pain or noticeable symptoms, this bacteria can lead to far more serious conditions. We are continuing to learn that gum disease may heighten the risk for heart disease, diabetes, pregnancy complications and other conditions.

- Chronic diseases – such as **heart disease**, stroke, **cancer**, **diabetes**, and arthritis – are among the most common, **costly, and preventable** of all health problems in the U.S.
- The presence of bacteria in active periodontal disease leads to inflammation, which can reduce **diabetic control.**
- Experimental models have linked the bacteria found in the plaque of the **arterial walls** to those found in the **periodontal pockets.**
- Bacteria contributes to inflammation that increases plaque build-up in the **small arteries of the heart**, restricting blood flow to the heart muscle, which can lead to a **heart attack.**
- The bacteria present in **periodontal disease has been found in amniotic fluid and the mother's placenta.**
- Mothers with **periodontal disease have a higher incidence of pregnancy complications.**

Emergency Dental Services

If you are ***within*** seventy-five (75) miles of your Selected General Dentist, simply contact your selected dentist who will make reasonable arrangements for such emergency dental care. If you are ***more than*** seventy-five (75) miles from your Selected General Dentist, or you cannot reach your Selected General Dentist or UHC Customer Service at (866) 528-6072, you may obtain Emergency Dental Services from any licensed dentist.

Potential examples of emergency are excessive bleeding, severe pain or acute infection. Reference the Dental Plan Documents for specifics at www.harriscountytx.gov/hrrm.

FILLING OPTIONS TO CONSIDER

"Fillings" - Amalgam is the silver filling that dentists have been using for many years to fill cavities; resin-based composite fillings are white (tooth colored). You may have heard about the safety concern of using amalgams because mercury is part of the filling material. However, the American Dental Association, the National Institutes of Health, and the U.S. Public Health Service, among others, have stated that, when combined with other metals, as it is in amalgam, it is an acceptable standard of treatment.

Because some dentists have a concern about using amalgam material, they choose to provide only composite fillings for their patients. We suggest you discuss with your dentist his or her practice policies.

"Crowns" - A crown is a metal cap that covers and strengthens a tooth. Crowns are generally necessary along with a root canal or when a standard filling is not enough support for the tooth structure. Crowns are made of different materials; metal only or a porcelain ("tooth-colored"). A crown is not just the cap that sits over the tooth…there can be other procedures and materials required, such as a gold post, a core build up or a pin…each one adds to the total cost.

Crown costs vary depending on the materials used – your dentist can provide an itemized treatment plan. For the DHMO plan, each covered crown is listed on your Schedule of Benefits. Check the copayment and any additional fees that are indicated [i.e. porcelain on back teeth and additional lab fees for noble (low gold) and high noble (high gold) metals].

Other procedures may be required during your treatment, such as a root canal - this adds to the cost of restoration. Under the PPO plan your benefit allowance is 50%, whether your dentist is in or out-of-network. The out-of-network dentist may balance bill for services above the maximum allowable charge fee schedule. You have greater savings when you choose a network dentist.

The Harris County Vision Care Program is offered through Block Vision.

Vision coverage is provided automatically for you and each dependent you enroll in the medical plan.

With the vision plan, when you use participating providers you will pay lower out-of-pocket expenses and receive a higher level of benefits. You may also use out-of-network benefits; however, your benefit level is reduced, you will pay for the services and you must file a claim with Block Vision for reimbursement.

HOW THE VISION CARE PROGRAM WORKS

Each time you need vision care, you may seek care through the Block Vision benefit plan. Select a ***Block Vision*** participating provider by calling the provider locator at (866) 265-0517, or from www.blockvision.com. When you make your appointment, identify yourself as a Harris County ***Block Vision*** Plan member. A vision examination is provided by a network optometrist or ophthalmologist once every twelve months.

At an in-network provider, members will receive a $130 retail allowance towards the cost of the frame. The Block Vision benefit plan provides $130 toward your contact lens evaluation and fitting fee as well and the cost of contact lenses. A $300 Lasik benefits reimbursement is also available either in or out-of-network in lieu of other benefits.

COVERED SERVICES

Highlights of your vision care benefits are shown in the chart. Copayments are not applicable when utilizing out-of-network providers.

For the complete schedule of benefits, reference the Vision Plan Benefit Certificate of Coverage at:
www.harriscountytx.gov/hrrm

VISION BENEFIT COVERAGE

Service/Product	In-Network	Out-of-Network
Complete Visual Exam*	$10 copay	Up to $35
Materials (when purchasing eyeglasses, lenses, frames OR contacts in lieu of eyeglasses)	$25 copay	
Frames		
	$130 retail allowance after $25 Materials copay	Up to $70
Lenses		
Single Vision Lenses**	Standard basic lens covered at 100% after $25 Materials copay	Up to $25
Lined Bifocal Vision Lenses**	Standard basic lens covered at 100% after $25 Materials copay	Up to $40
Lined Trifocal Vision Lenses**	Standard basic lens covered at 100% after $25 Materials copay	Up to $45
Contact Lenses		
Elective	$130 retail allowance after $25 Materials copay	Up to $80
Necessary***	100% after $25 Materials copay	Up to $150
Laser Correction		
Lasik Vision Correction****	$300 benefit	$300 retail benefit

*Limited to one exam and set of lenses or contacts every 12 months from the last date of service.

**Standard basic lens coverage included in your $25 copay for glasses lenses or frames and lenses. Lens cost that exceeds the basic coverage is the member's responsibility. Members may receive a discount of up to 20% from a participating provider's usual and customary fees for eyewear purchases which exceed the benefit coverage.

***Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Block Vision concerning the reimbursement that Block vision will make before you purchase such contacts.

****Lasik Vision Correction: Block Vision provides each member a $300 allowance available both in and out-of-network. ***Block Vision*** has partnered with the LCA. In-network providers may offer additional savings and financing. Call 877-557-7609 for assistance in coordinating your care.

URGENT CARE CENTERS & WALK-IN CLINICS in the Greater Houston area

Urgent care facilities are traditionally used to treat the sudden onset of illness or unexpected injury. Overcrowding of our emergency rooms for non-emergent services is an epidemic and unnecessary expense in many cases for the patient, the employer and the health plan. Urgent care facilities generally result in shorter wait times, **lower expenses and less out-of-pocket cost for our retirees since the copayment is $50 per visit vs. the hospital emergency room copayment of $300.**

Urgent care facilities fill a critical need for patients when they are seeking immediate care that is not life threatening and their general practitioner is unavailable. For example, a patient with a sprain, fracture, minor burns, skin rashes, possible infection, illness with nausea, vomiting and/or diarrhea, sore throat, fever, earache or minor laceration(s) may go to an urgent care facility if their doctor's office has already closed. If a patient feels like their situation is life threatening, then they should seek help in the appropriate setting or call 9-1-1. Retirees should continue to coordinate their care with the advice of their primary care physicians. Most urgent care centers are independent facilities. If they are connected to a hospital, the copayment is generally $300 per visit.

Some of the facilities listed are considered "walk-in clinics" and they are marked with an asterisk (*) and shaded gray. These clinics generally offer similar services to urgent care centers and are staffed by nurse practitioners. Your copay at the walk-in clinics is only $25 on the Base Plan and $20 on the Plus Plan. This summary is intended for reference purposes only, and medical conditions vary by individual. Always use your best judgment when seeking treatment for you and your family. *The urgent care centers and walk-in clinics listed are located in Houston unless otherwise indicated. This listing represents current providers and may be subject to change. It is your responsibility to check the provider's status and hours of operation when you seek service.*

North (Montgomery Co.) - includes :	**Conroe, The Woodlands, Montgomery, Spring, Kingwood, Houston**	
Lake Area Urgent Care	15320 Hwy. 105 West, Suite 120 Montgomery	(936) 582-5660
MinuteClinic* (CVS)	25110 Grogans Mill Rd., Spring	(866) 389-2727
Oaks Urgent Care	25410 IH 45 North, Spring	(281) 363-5600
RediClinic* (H-E-B)	2108 North Frazier, Conroe	(936) 494-4350
RediClinic* (H-E-B)	130 Sawdust Road, Spring	(281) 419-3162
RediClinic* (H-E-B)	10777 Kuykendahl Road, Spring/The Woodlands	(281) 907-4104
Take Care* (Walgreens)	24917 FM 1314 Road, Porter	(866) 825-3227
Take Care* (Walgreens)	8000 Research Forest Drive, The Woodlands	(866) 825-3227
Texas Family Medical & Minor Emergency Center	1331 Northpark Drive, Kingwood	(281) 359-5330

E/NE (Liberty County)		
Quality Care Plus	2718A North Main Street, Liberty	(936) 336-3616
N/NW/NE (Harris Co.) - Includes:	**Cypress, Humble, Kingwood, N/NW Houston, Tomball**	
Concentra Health Services, Inc.	401 Greens Road	(281) 873-0111
Concentra Health Services, Inc.	6360 W. Sam Houston Pkwy. North, Suite 200	(713) 280-0400
Concentra Health Services, Inc.	8799 North Loop East, Suite 110	(713) 674-1114
CyFair Urgent Care	9110 Barker Cypress Rd., Cypress	(281) 517-9900
Excel Immediate Medical Care	25801 U.S. Hwy. 290, Cypress	(281) 304-1100
Kingwood Urgent Care & Special Clinic	2601 W. Lake Houston Pkwy. Kingwood	(281) 360-7502
MinuteClinic* (CVS)	8000 N. Sam Houston Pkwy East Humble	(866) 389-2727

N/NW/NE (Harris County - Includes:	Cypress, Humble, Kingwood, N/NW Houston, Tomball	
MinuteClinic* (CVS)	24802 Aldine Westfield, Spring	(866) 389-2727
MinuteClinic* (CVS)	8754 Spring Cypress Rd., Spring	(866) 389-2727
Night Light Pediatric Urgent Care	19708 Northwest Frwy, Suite 500	(713) 957-2020
RediClinic* (H-E-B)	28520 Tomball Pkwy., Tomball	(281) 255-3085
RediClinic* (H-E-B)	4303 Kingwood Drive, Houston	(866) 607-7334
RediClinic* (H-E-B)	10919 Louetta	(281) 758-2282
RediClinic* (H-E-B)	24224 Northwest Freeway, Cypress	(866) 607-7334
RediClinic* (H-E-B)	7405 FM 1960 East, Humble	(866) 607-7334
Take Care* (Walgreens)	1215 West 43rd Street	(866) 825-3227
Take Care* (Walgreens)	7440 FM 1960 Road East Humble	(866) 825-3227
Take Care* (Walgreens)	19710 Holzwarth Road, Spring	(866) 825-3227
Take Care* (Walgreens)	16211 Spring Cypress Road Cypress	(866) 825-3227
Texas Urgent Care	10906 FM 1960 Road West @ Jones Road	(281) 477-7490
Westfield Urgent Care	2010 FM 1960 East	(281) 821-8200
East (Jefferson County) - includes:	**Beaumont, Nederland**	
Doctors Express of the Beaumont Area, P.A.	3195 Dowlen Road, Suite 105 Beaumont	(409) 860-1888
MinuteClinic* (CVS)	2712 State Highway 365, Nederland	(866) 389-2727

East/SE/South (Harris County) - includes :	E. Houston, Baytown, Pasadena, Deer Park, Clear Lake Area & Central Houston	
Baytown Urgent Care Limited	2800 Garth Road, Baytown	(281) 425-3835
Beamer Urgent Care	10851 Scarsdale Blvd., Ste 130	(281) 481-9595
Concentra Health Services, Inc.	10909 I-10 East Frwy.	(713) 973-7943
Concentra Health Services, Inc.	8505 Gulf Freeway, Suite F	(713) 944-4442
Concentra Health Services, Inc.	125 East 8th Street, Deer Park	(281) 930-8555
East Houston Urgent Care	11410 1-10 East, Suite 168	(713) 453-9800
Immediate Medical Care	1202 Nasa Parkway, Nassau Bay	(281) 335-0606
Primary Urgent Care	2802 Garth Rd., Baytown	(281)838-8575
RediClinic* (H-E-B)	6210 Fairmont Parkway, Pasadena	(832) 775-0165
RediClinic* (H-E-B)	9828 Blackhawk Blvd.	(713) 991-0497
Take Care* (Walgreens)	16185 Space Center Boulevard	(866) 825-3227
Take Care* (Walgreens)	3300 Center Street, Deer Park	(866) 825-3227
Urgent Care MDs	1658 W. Baker Road, Suite A Baytown	(281) 428-0000
SE/South (Galveston County) - includes:	**Friendswood, League City & Galveston**	
Calder Urgent Care	1100 So. Gulf Freeway, Suite 230 League City	(281) 557-4404
Friendswood Urgent Care	1305 West Parkwood Drive Friendswood	(281) 648-4800
RediClinic* (H-E-B)	701 West Parkwood, Friendswood	(281) 947-0018
RediClinic * (H-E-B)	2955 South Gulf Frwy., League City	(281) 337-7351
West Isle Urgent Care	2027 61st Street, Suite B Galveston	(409) 744-9800

South/SW (Brazoria County) - includes:	Angleton, Lake Jackson & Pearland	
Angleton Urgent Care	2327 East Hwy. 35, Angleton	(979) 848-8070
Minute Clinic* (CVS)	2900 E. Broadway St., Pearland	(866) 389-2727
Options Urgent Care & Wellness Ctr.	208 Oak Dr., Ste. 502, Lake Jackson	(979) 285-2273
Pearland Healthcare Center	1801 Country Place Pkwy, Suite 109, Pearland	(713) 436-4333
Prime Urgent Care	2510 Smith Ranch Road, Pearland	(713) 340-3111
RediClinic* (H-E-B)	2805 Business Ctr. Dr., Pearland	(713) 436-5208
Take Care* (Walgreens)	8430 Broadway St., Pearland	(866) 825-3227
Central /SW (Harris Co.)	**Houston**	
Concentra Health Services, Inc.	9321 Kirby	(713) 797-0991
Concentra Health Services, Inc.	6545 Southwest Frwy.	(713) 995-6998
Concentra Health Services, Inc.	2004 Leeland	(713) 223-0838
Five Star Urgent Care	5749 San Felipe	(713)972-0800
Houston Medical Care	5568 Weslayan Street	(713) 666-7050
Minute Clinic* (CVS)	5402 Westheimer Rd, Suite K	(866) 389-2727
RediClinic* (H-E-B)	2660 Fountainview	(866) 607-7334
Take Care* (Walgreens)	1919 West Gray Street	(866) 825-3227
Take Care* (Walgreens)	5200 Westheimer Road	(866) 825-3227
Take Care* (Walgreens)	2808 N. Gessner Road	(866) 825-3227

West/SW (Ford Bend Co.) - includes:	Katy, Missouri City, Stafford and Sugar Land	
Excel Urgent Care	6840 Hwy. 6, Missouri City	(281) 403-3660
Night Light After Hours Pediatrics	15551 Southwest Frwy., Sugar Land	(281) 325-1010
RediClinic* (H-E-B)	6711 South Fry Road, Katy	(281) 395-5080
RediClinic* (H-E-B)	8900 Highway 6, Missouri City	(866) 607-7334
RediClinic* (H-E-B)	19900 Hwy. 59, Sugar Land	(281) 341-8330
RediClinic* (H-E-B)	23675 Nelson Way, Katy	(866) 607-7334
Southwest Urgent Care	19875 Southwest Frwy., Ste 100 Sugar Land	(281) 545-2323
Take Care* (Walgreens)	6768 Hwy. 6 South	(866) 825-3227
West (Harris County)	Katy & West Houston	
Bunker Hill Urgent Care	9778 Katy, Suite 100	(713) 468-7845
Concentra Health Services, Inc.	1000 N. Post Oak Rd. Bldg. G-100	(713) 686-4868
Concentra Health Services, Inc.	12345 Katy Freeway	(281) 679-5600
Excel Urgent Care	19540 Katy Freeway	(281) 829-9900
Katy Urgent Care Partners	21700 Kingsland Blvd., Ste. 104 Katy	(281)829-6570
Minute Clinic* (CVS)	3103 N. Fry Road, Katy	(866) 389-2727
RediClinic* (H-E-B)	9710 Katy Freeway	(866) 607-7334
Take Care* (Walgreens)	411 South Mason Rd., Katy	(866) 825-3227
West Oaks Urgent Care	2150 South Hwy. 6, Suite 100	(281) 496-4948

*** Walk-in clinics are marked with an asterisk (*) and shaded gray. Your copay at the walk-in clinics is only $25 on the Base Plan and $20 on the Plus Plan.**

IMPORTANT INFORMATION ABOUT MEDICARE DIRECT

Enjoy effortless claim filing for your Medicare Part B supplemental expenses! How can you simplify filing your supplemental claims? If you are currently enrolled in Medicare Part B and Aetna is your secondary carrier, the answer is Medicare Direct! Medicare Direct is an electronic service that eliminates your need to file claims for supplemental benefits! Medicare pays its share of the expenses, and then automatically forwards any remaining expenses directly to Aetna. All you have to do is wait for your supplemental reimbursement from Aetna — no more time-consuming paperwork to fill out.

Medicare Direct offers the following advantages for you and your eligible dependents (if also covered under Medicare Part B):

An end to paperwork - Once you are enrolled in Medicare Direct, you won't have to send forms or Explanation of Medicare Benefits (EOMB) statements to Aetna in order to get your supplemental benefit (as long as you've filed a Medicare Part B claim within the last year.)

Quicker turnaround - The Medicare Part B carrier sends your claims straight to Aetna with no time wasting middle steps and **no postage -** Medicare Direct connects Medicare and Aetna electronically, eliminating postage.

HERE'S HOW MEDICARE DIRECT WORKS FOR YOU

- **Visit your provider**
- **Provider submits the claim to Medicare**
- **Medicare pays its portion of the claim and sends it directly to Aetna for processing**
- **Aetna pays covered expenses and notifies you**

Once your provider files a claim for your Medicare Part B expenses with your Medicare Part B carrier, Medicare Direct takes care of the rest. It does just what the name suggests. After Medicare has paid its share of the expenses, Medicare forwards your remaining expenses **directly** to Aetna. There's no waiting for EOMB statements. There are no claim forms to fill out — no EOMB forms to copy — no postage costs. And there's no cost to you!

How will I know if my claim has been forwarded to Aetna? Check each Explanation of Medicare Benefits (EOMB) statement to be sure it includes a remark similar to "unpaid charges have been forwarded to your complementary insurer." Your complementary insurer is Aetna. If the remark is not there, you will need to file the claim yourself, as you do today.

Does my doctor need to know? YES. You should tell your doctor you are enrolled in Medicare Direct. With Medicare Direct, it's important that your doctor not submit claims to Aetna for supplemental benefits. Medicare will file claims automatically to Aetna if your doctor accepts Medicare assignment. If s/he has opted out of Medicare, you must file your claim with Medicare and then Aetna will pay secondary as an out-of-network claim. For more information reference page 26 of this Guide.

Getting started is easy. As the retiree, you have been automatically enrolled in Medicare Direct if your Medicare Number is your Social Security number, followed by the letter "A". If your Medicare Number is not your Social Security number followed by the letter "A", you are not enrolled in Medicare Direct. We are unable to automatically enroll your spouse/eligible dependent. To do so, contact Aetna directly at 1-800-279-2401. Please do not mail claim forms, as it will delay the processing of your claim. If you have a claim that needs to be filed before your enrollment in Medicare Direct, you will need to send it to the address on your medical ID card. There is no charge to you for this service. So, be sure to register as soon as you are eligible. **That's all there is to it!**

LIFE INSURANCE & MEDICARE REVIEW

Basic Life Insurance for Retirees provided by: Prudential

Harris County provides life insurance protection for your family in the event of your death.

Annual rate of basic earnings at retirement	Benefit
$20,000 or more	$12,500
$15,000 but less than $20,000	$10,000
$10,000 but less than $15,000	$7,500
Less than $10,000	$ 5,000*

*Some retirees may have less than $5,000 coverage depending on their salary upon retirement.

MEDICARE PARTS A & B

Medicare becomes the primary insurer when a retiree, or a dependent of a retiree turns 65 or becomes eligible due to disability. Harris County medical benefits then become secondary to Medicare.

The Harris County Medical Plan coordinates its benefits with Medicare Parts A & B. Since Medicare is the primary insurance, it must pay benefits first then the Harris County Medical Plan will pay benefits. The Harris County Medical Plan will pay benefits as if Medicare part B paid first even if you are not enrolled in Medicare part B**.** This will cause a gap in your coverage if you do not enroll in Medicare part B as a retiree.

You should contact the Social Security Administration at 1-800-772-1213 if you have any questions concerning coordination of benefits between the Harris County Medical Plan and Medicare.

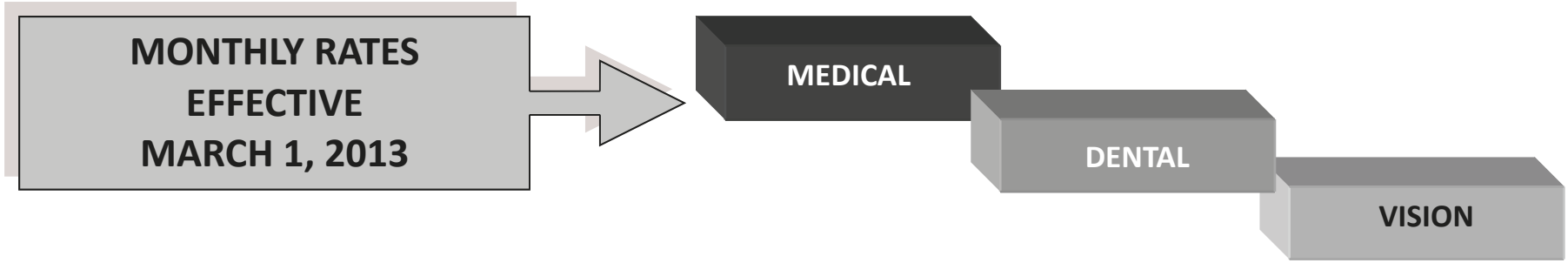
A WORD ABOUT PROVIDERS ACCEPTING MEDICARE…If your physician accepts Medicare assignment s/he will bill Medicare for you. If your physician does not accept Medicare assignment and/or has opted out of Medicare, you may be responsible for filing your claim with Medicare yourself. Effective 3/1/2013, Aetna will not pay primary for retirees who are eligible for Medicare if your provider has opted out of Medicare. You should ensure that all of your medical providers participate in Medicare and are in Aetna's network to receive the highest level of benefits. Failure to do so, will result in higher out-of-pocket costs for you.

MEDICARE PART D

Harris County Medicare eligible employees and retirees should NOT enroll in Part D— Medicare Prescription Drug Plan. Enrollment in a Medicare Prescription Drug Plan is voluntary, but in most cases it is **unnecessary because the Harris County Medical Plan administered through Aetna provides more comprehensive prescription drug coverage.** In addition, there is **no** coordination of benefits between Harris County's medical plan and the Medicare Prescription Drug Plan; however, there will continue to be coordination with Medicare Parts A and B.

If you meet certain income and resource limits, you may qualify for Extra Help from Medicare to pay the costs of Medicare prescription drug coverage. You may qualify if you have up to $16,755 in yearly income ($22,695 for a married couple) and up to $13,070 in resources ($26,120) for a married couple. If you don't qualify for Extra Help, your state may have programs that can help pay your prescription drug costs. Contact your State Health Insurance Assistance Program (SHIP) for more information. Remember, you can reapply for Extra Help at any time if your income and resources change.

For more information about getting help with your prescription drug costs, call Social Security at 1-800-772-1213 or visit **www.socialsecurity.gov.** If you or any of your covered dependents are eligible for additional coverage through **Medicaid**, you should contact 1-800-MEDICARE (1-800-633-4227) or visit **www.medicare.gov** to determine the best prescription drug option for you.

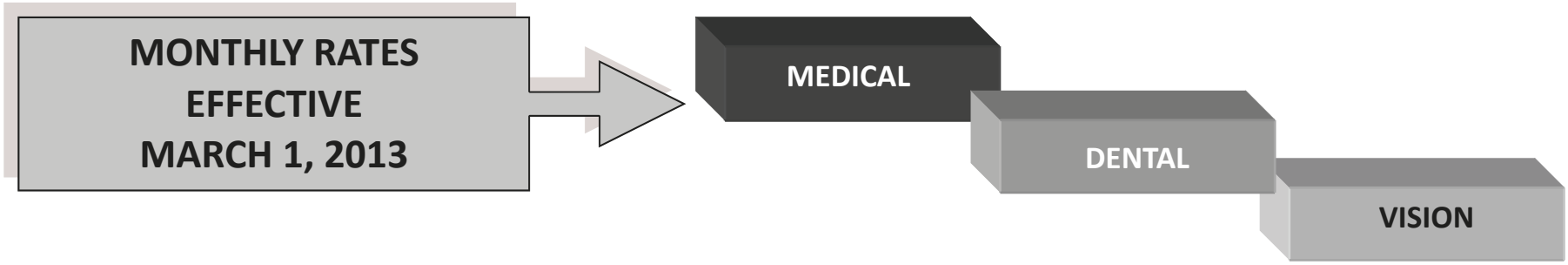


Rates apply to non-Medicare eligible Retirees

	BASE MEDICAL PLAN W/PPO DENTAL			BASE MEDICAL PLAN W/DHMO DENTAL		
	Retiree Cost	County Cost	Total Cost	Retiree Cost	County Cost	Total Cost
Retiree Only < 65	$115.52	$481.06	$596.58	$115.52	$476.37	$591.89
Retiree + Spouse	$360.31	$726.51	$1,086.82	$357.59	$719.43	$1,077.02
Retiree + Child	$334.94	$701.14	$1,036.08	$332.22	$694.06	$1,026.28
Retiree + Two or More	$512.84	$880.98	$1,393.82	$494.77	$857.71	$1,352.48

	PLUS MEDICAL PLAN W/PPO DENTAL			PLUS MEDICAL PLAN W/DHMO DENTAL		
	Retiree Cost	County Cost	Total Cost	Retiree Cost	County Cost	Total Cost
Retiree Only < 65	$194.97	$623.08	$818.05	$194.97	$618.39	$813.36
Retiree + Spouse	$568.60	$997.38	$1,565.98	$565.88	$990.30	$1,556.18
Retiree + Child	$495.48	$924.25	$1,419.73	$492.76	$917.17	$1,409.93
Retiree + Two or More	$733.11	$1,163.82	$1,896.93	$715.04	$1,140.55	$1,855.59

NOTE: If you are currently covering dependents, Harris County may pay a portion of the cost of your dependents' coverage as well. If you retired after March 1, 2002 or if you retired with less than 10 years of Harris County service, your rates may vary. Please review your Enrollment Worksheet to determine the monthly rate for the 2013-2014 plan year for you and your currently covered dependents.



Rates apply to Retirees over the age of 65 or Retirees otherwise eligible for Medicare Parts A & B.

	BASE MEDICAL PLAN W/PPO DENTAL			BASE MEDICAL PLAN W/DHMO DENTAL		
	Retiree Cost	County Cost	Total Cost	Retiree Cost	County Cost	Total Cost
Retiree Only 65+	$0	$481.06	$481.06	$0	$476.37	$476.37
Retiree + Spouse	$244.79	$726.51	$971.30	$242.07	$719.43	$961.50
Retiree + Child	$219.42	$701.14	$920.56	$216.70	$694.06	$910.76
Retiree + Two or More	$397.32	$880.98	$1,278.30	$379.25	$857.71	$1,236.96

	PLUS MEDICAL PLAN W/PPO DENTAL			PLUS MEDICAL PLAN W/DHMO DENTAL		
	Retiree Cost	County Cost	Total Cost	Retiree Cost	County Cost	Total Cost
Retiree Only 65+	$67.13	$623.08	$690.21	$67.13	$618.39	$685.52
Retiree + Spouse	$440.76	$997.38	$1,438.14	$438.04	$990.30	$1,428.34
Retiree + Child	$367.64	$924.25	$1,291.89	$364.92	$917.17	$1,282.09
Retiree + Two or More	$605.27	$1,163.82	$1,769.09	$587.20	$1,140.55	$1,727.75

Harris County pays a significant portion of the cost for your health care coverage. The amount of Harris County's contribution is determined annually and is currently based on your years of Harris County service and age at retirement. As a general rule, if you retired before March 1, 2002 with at least 10 years of Harris County service, for the 2013-2014 benefit year Harris County will pay 100% of the cost of your BASE plan medical, dental, vision and life insurance coverage if you are Medicare eligible and/or over the age of 65.

...find us on the web at:

www.harriscountytx.gov/hrrm

HUMAN RESOURCES & RISK MANAGEMENT
Benefits Division
1310 Prairie, Suite 400
Houston, TX 77002-2042

Phone: (713) 755-5117
Toll-free: (866) 474-7475
Fax: (713) 755-8659

Photo courtesy of Ben Giannantonio

COMMISSIONERS COURT

Ed Emmett—County Judge

El Franco Lee—Precinct 1 Commissioner

Jack Morman—Precinct 2 Commissioner

Steve Radack—Precinct 3 Commissioner

R. Jack Cagle —Precinct 4 Commissioner